Consent for the Release of Communicable Disease Information

I, _____, hereby

☐ authorize ☐ do not authorize _____ to release

(name of program/organization)

my name, address, telephone number to the Massachusetts Department Of Public Health, Division of Sexually Transmitted Disease/Tuberculosis Disease Intervention Specialist or other staff person who reviews Sexually Transmitted Disease or TB Treatment.

If information about my diagnoses and treatment for STDs or TB is needed to provide and review treatment for STDs or TB or to confirm that I am enrolled in this program in the event that I am identified as a person who may have contracted an infectious disease.

For the purpose of allowing agencies listed to provide and review the treatment I receive for STDs or TB and to help prevent the spread of these infectious diseases.

I understand that my STD records are protected under State Law Chapter 111, section 119 which states that my STD records shall not be closed except upon proper order by a judge or to a person whose job, in the opinion of the Commissioner of Public Health, entitles him or her to receive the information. TB case records are also kept confidential under state laws and the same protections apply.

I understand that my drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records 42 CFR Part 2, Subpart C and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may cancel this consent at any time except to the extent that action has already begun. If not previously cancelled this consent will terminate in 6 months or will last no longer than reasonably necessary to complete STD or TB treatment.

Laboratory tests conducted in the course of Public Health activities may be sent to the State Health Department or its designees, but will remain confidential as described in Section 5.

_____

(Specification of the date, event, or condition upon which this consent expires)

_____

Dated: _____

_____

Signature of Resident

_____

Signature of Witness (optional)